Editorials

Prevention of mental illness must start in childhood:

growing up feeling safe and protected from harm

SOCIAL FACTORS UNDERLYING MENTAL ILL HEALTH

I recently completed a review of research on mental illness in search of lessons for how it could more effectively be reduced.[1] Since a similar exercise completed in 1988 for MIND,[2] genetic studies have advanced considerably, while research on social factors has largely continued to confirm the key role of child maltreatment in creating vulnerability, and the importance of stressful life events in triggering or provoking an onset, with social support (particularly in its negative form) a key mediating factor. The most exciting developments arguably have been in the area of epigenetics, which have given a whole new meaning to the concept of gene–environment interaction. It seems that not only do inherited personality characteristics affect how we interpret experience — and play a role in behaviour and life circumstances (that is, making some people more liable to experience stressful events or gain social support) — but social factors, such as early child maltreatment, actually change the expression of the genome.[3] This, in turn, creates a lasting susceptibility to common psychiatric disorders in the wake of adult stressful experience.

It also suggests that the most effective preventive work will be that which starts as early in life as possible.[4] The importance of the emotional health as well as the physical health and nutrition of the pregnant woman and new mother, and the stressfulness of her environment, may have been underestimated. It seems that above all else, the infant and child needs to feel secure: that at least one person cares about them enough to stand between them and danger, and is capable of keeping them safe.[1]

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IMPLICATIONS FOR PRIMARY CARE

What are the implications for the family doctor? Of central importance is their potential role in reducing child maltreatment. Maltreatment affects vulnerability to common conditions like depression and anxiety right through to old age;[5] it is important in a whole range of mental health conditions, and is associated most strongly with chronic disorder.[6] The most common forms are maternal neglect or indifference, and emotional abuse, such as rejection, and physical abuse by fathers, each strongly associated with later depression[6] and increasing susceptibility to most forms of anxiety. All forms of abuse from either parent occur more often where there is marked discord between adults in the home, parental substance misuse, a criminal history, or maternal depression.[7] A combination of these factors can be lethal, as shown by so many of the reviews of infant deaths.[8]

FOCUSING INTERVENTION

Among the many factors associated with parenting problems and child maltreatment, two have particular significance in primary care. The first is the strong relationship between enduring maternal mental ill health and difficulties in the child.[1] Parental mental ill health distinguishes between samples of children with and without a disorder in nearly all countries, and is independently associated with persistent emotional and conduct disorder in the child.[9] Such children also have an increased likelihood of physical illness and special educational need, suggesting the link with maternal mental ill health might be a reciprocal one.

The second is the marked difference in the social circumstances of mothers having a first child around or before the age of 20 years compared with women who do so at what is now the norm: 10 years later. The younger mothers are likely to have much less support; more often be single parents, or to also have stepchildren, quarrelsome or abusive relationships, and financial hardship.[1] Young women leaving care are over-represented among this group, and they will often share not only an experience of maltreatment, but also very commonly of special educational need, and physical illness. Not surprisingly, about 45% of care leavers have an existing clinical level of mental ill health.[10]

Together these factors suggest a need for greater investment of time and resources toward the youngest mothers during pregnancy and during their child's early years; and when treating any parent with mental ill health, exploring the impact on parenting, and their support with child care at home. Of course, raising issues of parenting in such circumstances can be challenging, and would need to be done with care, but is essential. It has been argued that in fact, far from jeopardising the therapeutic relationship, an open discussion can alleviate fear, reducing stigma by recognising the person in their parenting role.[8]

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ACHIEVING CHANGE

Helping people considered to need additional support is difficult to get right, as most doctors and social workers know well, and as the many disappointing randomised controlled trial evaluations confirm.[1] There is evidence that intensive health visitor programmes targeting disadvantaged mothers can be very effective,[11] as can interventions to reduce teenage pregnancy, and parenting education programmes such as the Triple P Positive Parenting Program (www.triplep-parenting.uk.net/uk-en/home/). But there are at least as many examples of such programmes that show little or no benefit.[1]

In some cases, it seems that accepting an offer of help can have a cost to self esteem, and well-intentioned offers are rejected. Support that is offered because the person is thought to need it, is often far less valuable than help that is sought. A similar difficulty can be created when establishing a support group where participants share low aspirations, poor achievement, or social disadvantage, as it can reinforce an identity associated with low status and low expectations, particularly if the focus is then on their 'problems'. A case can be made for including in such groups peers with a more aspirational, self-confident, and sexually-cautious outlook. A programme based on a selection of all first-time mothers aged ≤20 years may achieve this, together with an aspirational focus on child development and achievement.

A first pregnancy is a potential turning point, certainly a transition, which usually brings a willingness to engage.[11] But Olds also argues that the focus should not be on problems or deficits, but on the mother's own longer-term goals, helping her to develop a vision for her future *'and then make smart choices about planning future pregnancies, completing ... education, and finding work'*. Also important is to help strengthen supportive relationships with family members and friends, and to link the family with other services.

Voluntary mentoring or befriending organisations may help, and links between a general practice and organisations like Newpin or Homestart, or those set up to help women escape domestic violence, can be important. Outside support that makes a difference is most likely to come from those whose opinions matter, people who have achieved the status of trusted adult or trusted friend, or trusted expert ally. Health visitors' views about parenting and child health matter, but peers may be more important to decisions about relationships and employment.

A recent *BJGP* editorial summarising the NSPCC study on the role of the GP in child protection[12] found, not surprisingly, that GPs already identify a substantial number of maltreated and vulnerable children. It also emphasises, as argued here, the need to draw on the full role of the traditional family doctor to support and advocate on behalf of the family (and as the discussion here suggests, particularly the youngest pregnant women and new mothers with depression), including help to resolve social problems, and to become and remain their patient's 'trusted ally'.

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